THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-2687.M5

MDR Tracking Number: M5-04-0125-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 09-09-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the myofascial release and office visits on 09-12-02 through 05-08-03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 09-12-02 through 05-08-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 19th day of December 2003.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

December 18, 2003

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED DECISION
Correcting disputed dates of service
09-12-02 through 05-08-03

Re: MDR #: M5-04-0125-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant

medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:
This female patient sustained a work-related injury to her shoulder and cervical region. She has undergone long-term management of this condition since 09/21/93. Management has included epidural steroid injections, chiropractic rehab, nerve blocks, Botox injections, and a cervical fusion.

It should be noted that, in the opinion of the reviewer, insufficient records were initially provided for review. Additional records were requested, received and provided to the reviewer.

Disputed Services:
Myofascial release and office visits during the period of 09/12/02 through 05/08/03.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the services in question were not medically necessary in this case.

Rationale:
According to the *Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters*, published by the TCA in 1994, chronic episodes of symptoms that are unresponsive to care should be weaned from passive therapy normally designed to manage acute and sub-acute conditions. Continued failure to respond to treatment should result in the discharge of the patient based on having achieved maximum therapeutic benefit, or being inappropriate for chiropractic care. This is referenced in Chapter 8, Section 4-D, Subsection 2 and Subsection 5. Also, supportive care for chronic symptoms using passive therapy may be necessary if repeated efforts to withdraw from treatment/care result in significant deterioration of clinical status, as referenced in Chapter 8, Section 6-F, Subsection 3.

The records reviewed for the dates in question show no significant change in overall symptoms and no objective benefits are documented apart from subjective comments noted by the treating doctor. Also, there is no documentation showing significant deterioration of the patient's status without receiving care. The reviewer is of the opinion that the treatment dates of continued use of passive therapies in question were not medically necessary, as they are promoting physician dependence and chronicity and are not showing objective benefits.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,